American Bankers Life Assurance Company of Florida
P.O. Box 977122, Miami, FL 33157 • 1.800.327.5288 • Fax 1.305.252.6910

DEATH CLAIM FORM

Fax completed form and any attachments to 1.305.252.6910

Claims Department use only	
CLAIM NUMBER	DATE PROCESSED / /

PLEASE HAVE THE DECEASED INSURED'S NEXT-OF-KIN COMPLETE AND SIGN THE REVERSE SIDE.

CREDITOR'S STATEMENT		PLEASE PRINT
INSURED'S NAME	DATE OF DEATH / /	SOCIAL SECURITY NUMBER - -
CERTIFICATE NUMBER		MONTHLY PAYMENT $
LOAN NUMBER	DATE OF LOAN / /	FIRST PAYMENT DUE DATE / /

BENEFIT CALCULATION

1. Original amount of insured's indebtedness $ ____________________
2. Gross amount paid of credited thereon $ ____________________
3. Gross unpaid balance at death $ ____________________
4. Unearned interest paid or credited $ ____________________
5. Net unpaid balance due creditor $ ____________________
6. Amount of insurance, if any, to Second Beneficiary $ ____________________

NAME OF CREDITOR/BENEFICIARY			TELEPHONE NUMBER ( )
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME OF SECOND BENEFICIARY		RELATIONSHIP TO THE DECEASED	

I hereby certify that the information shown above is true and correct and with respect to the benefits being claimed hereunder, and I further certify that attached Death Certificate identifies this insured borrower.

NAME OF PERSON COMPLETING THIS SECTION (PLEASE PRINT)	SIGNATURE X	DATE / /

PLEASE ATTACH:

1. CERTIFIED COPY OF DEATH CERTIFICATE
2. COPY OF THE NOTE/INSTALLMENT CONTRACT
3. COPY OF CERTIFICATE OF INSURANCE

(See Reverse Side)

NEXT-OF-KIN AUTHORIZATION

PLEASE HAVE THE INSURED'S NEXT-OF-KIN COMPLETE AND SIGN THE FOLLOWING

Give all the names and addresses of any physicians, hospitals, organizations or other persons who attended the deceased insured during the past 2 years. This would also include pharmacy information.

PLEASE PRINT

NAME	STREET ADDRESS / CITY / STATE / ZIP CODE	TELEPHONE NUMBER	DATE OF ATTENDANCE	DISEASE OR CONDITION
		( )	/ /	
		( )	/ /	
		( )	/ /	
		( )	/ /	
		( )	/ /	

AUTHORIZATION TO OBTAIN INFORMATION

I authorize any employer, physician, hospital, clinic, other medical or medically related facility, the Medical Information Bureau, Inc., Consumer Reporting Agency, insurance or reinsuring company, insurer law enforcement agency, fire department or other organization or person having any records, data, or information concerning the deceased insured to furnish such record, data, or information to the insurance company or any of its subsidiaries or its authorized representative(s) as requested. I also authorize any union, trust fund, employer or insurance carrier to release information for:

NAME				DATE OF BIRTH / /
STREET ADDRESS	CITY	STATE	ZIP CODE	

I understand that in executing this authorization, I waive the right for such information to be privileged as it pertains to the processing or investigation of the deceased insured's claim(s). A photocopy of this authorization shall be considered as effective and valid as the original.
I understand and acknowledge that this authorization extends to all or any part of the records being requested, which may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis and treatment. I expressly consent to the release of information as designated above.

I may revoke this authorization by notifying ______________________________ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

The above information is true and correct. If, in fact, the furnished information is false thereby inducing payment of claim and the insurance company or any of its subsidiaries determines that the incorrect information constitutes an aiding and abetting the filing of a fraudulent claim, the insurance company may furnish the needed information to the appropriate state authorities to be used in its discretion as the basis for action authorized under applicable state law. In addition, I agree any statements made on this or any other form found to be false shall give the insurance company or any of its subsidiaries the right to void the deceased insured's policy.

This authorization shall remain valid for the duration of the claim.

PRINT NAME	SIGNATURE X	RELATIONSHIP TO DECEASED	DATE / /	
STREET ADDRESS / APT #	CITY	STATE	ZIP CODE	TELEPHONE NUMBER ( )

FL residents only: Pursuant to § 817.234, Florida Statutes, any person who, with the intent to injure, defraud, or deceive any insurer or insured, prepares, presents, or causes to be presented a proof of loss or estimate of cost or repair of damaged property in support of a claim under an insurance policy knowing that the proof of loss or estimate of claim or repairs contains any false, incomplete, or misleading information concerning any fact or thing material to the claim commits a felony of the third degree, punishable as provided in § 775.082, § 775.083, or § 775.084, Florida Statutes.

OK residents only: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

TX residents only: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.